



FOUNDATION  
AGAINST  
INTOLERANCE  
& RACISM

June 10, 2022

The Honorable Xavier Becerra  
Secretary, U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1765-P, Mail Stop C4-26-05  
7500 Security Boulevard, Baltimore, MD 21244-1850

Submitted at <https://www.regulations.gov>.

**Re: file code CMS-1765-P (Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities To Establish Mandatory Minimum Staffing Levels)**

Dear Secretary Becerra and Administrator Brooks-LaSure:

The Foundation Against Intolerance & Racism (FAIR) is a nonpartisan, nonprofit organization dedicated to advancing civil rights and liberties and promoting a common culture based on fairness, understanding, and humanity. We have nearly 100 chapters and tens of thousands of members nationwide. Our website, [fairforall.org](http://fairforall.org), can give you a fuller sense of our identity and activities, including our federal [lawsuit](#) to stop New York City from enforcing its unconstitutional order prioritizing Covid-19 treatments based on skin color and ethnicity.

We write in response to three sections in the proposed rule beginning on page 22720 of the Federal Register, Vol. 87, No. 73 (Friday, April 15, 2022). Those sections are:

- VI.C. SNF QRP Quality Measure Proposals Beginning With the FY 2025 SNF QRP; 2. Revised Compliance Date for Certain Skilled Nursing Facility Quality Reporting Program Requirements Beginning With the FY 2024 SNF QRP (proposed rule, pp. 22750-3)
- VI.E. Overarching Principles for Measuring Equity and Healthcare Quality Disparities Across CMS Quality Programs—Request for Information (RFI) (proposed rule, pp. 22754-60)
- VII.I.4. Request for Comment on a SNF VBP Program Approach To Measuring and Improving Health Equity (proposed rule, p. 22789)

FAIR agrees with a number of important statements made in the proposed rule. For example, we agree that “[s]ignificant and persistent disparities in healthcare outcomes exist in the United States” and “[b]elonging to an underserved community is often associated with worse health outcomes” (p. 22754; similar statements are made on p. 22789). We also agree with CMS’s stated aim to “advance health equity, by which we mean the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health” (p. 22754). Further, we understand that measuring healthcare disparities using quality measures is important to achieving that aim.

Our concern with the proposed rule is that the collection and stratification of data on “race” and “ethnicity”—both of which are social constructs that have no reliable biological basis in the clinical context—could have several adverse consequences. These consequences include inappropriate care for individuals, distrust in healthcare providers and institutions, and deepening rather than alleviating the arbitrary division of human beings by “race” and “ethnicity.”

First, “race” is a social rather than a biological attribute. There is no biological basis for grouping all individuals who self-identify as, for example, “Asian” or “Hispanic or Latino,” into one group. Those are extremely broad groups comprising hundreds of millions or even more than a billion unique individuals who can and differ greatly from one another. The range of individual experiences within such groups is likewise immense. “Race” and “ethnicity” are so overly broad, vague, and ill-defined that, even in combination with other indicators, they are unlikely to provide useful information and may even obscure individual experience to the detriment of individualized patient care. We also note that

using the categories of “race” and “ethnicity” in clinical care will only become less accurate as our nation becomes more diverse. When respondents to the [2020 U.S. Census](#) were given more thorough and accurate ways to self-identify compared to those in the 2010 Census, “the percentage of people who reported multiple races changed more than all of the race alone groups, increasing from 2.9% of the population (9 million people) in 2010 to 10.2% of the population (33.8 million people) in 2020.” That number will likely grow exponentially. In addition, about “27.9 million people (8.4% of all respondents) identified as Some Other Race alone in 2020, up from 19.1 million people (6.2%) in 2010.”

Data on characteristics that are tied to the real root causes of disparities can and should be collected, *rather than* data on the unscientific, proxy categories of “race” and “ethnicity.” We note that CMS itself identifies a number of those other characteristics, such as the social risk factors of “socioeconomic status, housing availability, and nutrition (among others)” (p. 22756). CMS also states that “dual eligibility for Medicare and Medicaid has been found to be an effective indicator of social risk in beneficiary populations” (p. 22756) and identifies social determinants of health such as “transportation, health literacy [and] high-volume of emergency department (ED) use” (p. 22757).

Second, our concern regarding the collection and stratification of data based on race and ethnicity is deepened by CMS’s plan to report results publicly:

Confidential reporting, or reporting results privately to healthcare providers, is generally used for new programs or new measures recently adopted for programs through notice and comment rulemaking to give healthcare providers an opportunity to become more familiar with calculation methods and to improve before other forms of reporting are used. In addition, many results are reported publicly, in accordance with the statute (p. 22757).

We are not opposed to public reporting of quality data, which can drive quality improvement and accountability. However, CMS’s plan to collect and report data stratified by “race” and “ethnicity” is extraordinary given its own acknowledgement of the harms that may result from ill-considered public reporting. For example, CMS has acknowledged that reporting health disparities could have “unintentional consequences or biases in measurement that may exacerbate disparities in care” (p. 22755). In addition, CMS has noted that “[o]ne important consideration is to assess differential impact on SNFs, such as those located in rural or critical access areas, to ensure that reporting does not disadvantage already resource-limited settings” (p. 22757).

We believe collecting and reporting data stratified by “race” and “ethnicity”— whether confidentially or publicly—is highly likely to lead to the very consequences CMS fears: biased measurements and disadvantages to resource-limited settings. For example, an individual who is incorrectly grouped within a particular “race” may be given unnecessary treatments with potentially negative side-effects or other consequences. The use of such data by SNFs may also lead to inappropriate denial of care when facilities group individuals into categories that do not reflect their actual health status and needs but rather those of a “racial” or “ethnic” group to which they purportedly belong.

Most importantly, we believe public reporting of performance on “race” and “ethnicity” quality measures, and the use of such unscientific data to direct programs and care, is likely to lead to distrust of health providers and health-related institutions, including CMS. For example, patients may fear they will be offered inadequate care, unnecessary treatment, or the wrong type of care because of their “racial” categorization—even if they have been able to select the group to which they have been assigned.

The changes being considered in this proposed rule will only erode the quality of health care offered to Americans. Excellence in health care services, a goal we all share, comes from well-trained clinicians applying the most up-to-date information for an individual patient’s unique situation. Using broad and arbitrary categorizations to dictate care is the antithesis of personalized medicine.

For the reasons set forth above, we believe CMS’s inclusion of “race” and “ethnicity” in the proposed rule will worsen patient care and trust in health care providers. Therefore, we request the following action:

1. Removal of the requirements to collect data relating to “race” and “ethnicity” and to stratify data by “race” and “ethnicity.”
2. Removal of the requirement for Skilled Nursing Facilities to begin data collection for “race” and “ethnicity” on October 1, 2023.
3. Removal of the reference to estimating “race” and “ethnicity” using imputed data sources and the example given of the Medicare Bayesian Improved Surname Geocoding method, which “combines information from administrative data, surname, and residential location to estimate race and ethnicity of patients at a population level” (p. 22756).

4. Clarification in the final rule that CMS will not tie quality measures involving social risk factors like “race” and “ethnicity” to payment in the future. We believe any such connection to payment is likely unconstitutional.

Thank you again for this opportunity to provide input in response to CMS’s proposed rule. We appreciate the agency’s consideration of our concerns and recommendations.

Sincerely,

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